INSTITUTE FOR INTEGRATIVE NUTRITION®
THE WORLD'S LARGEST NUTRITION SCHOOL

Female Teen Health History

Please write or print clearly. All of your information will remain confidential between you and the Health Coach.

PERSONAL INFORMATION

First Name: _____

Last Name: _____

Email: _____ How often do you check email? _____

Phone: Home: _____ Work: _____ Mobile: _____

Age: _____ Height: _____ Birthdate: _____ Place of Birth: _____

Current weight: _____ Weight six months ago: _____ One year ago: _____

Would you like your weight to be different? _____ If so, what? _____

Why did you come for a Health History? _____

SOCIAL INFORMATION

What is your relationship status? _____

What grade are you in? _____ Do you enjoy school? Please explain: _____

_____

Do you have a large or small group of friends? _____

HEALTH INFORMATION

Please list your main health concerns: _____

_____

Other concerns? _____

Any serious illnesses/hospitalizations/injuries? _____

_____

How is/was the health of your mother? _____

How is/was the health of your father? _____

Where do your parents and grandparents come from? _____

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Female Teen Health History

HEALTH INFORMATION (continued)

How is your sleep? _____ How many hours? _____ Do you wake up at night? _____

Why? _____

Constipation/Diarrhea/Gas? _____

Allergies or sensitivities? Please explain: _____

FEMALE TEEN HEALTH

Are your periods regular? _____ How many days is your flow? _____ How frequent? _____

Painful or symptomatic? Please explain: _____

What is your birth control history? _____

Do you experience yeast infections or urinary tract infections? Please explain: _____

MEDICAL INFORMATION

Are you concerned with body image? Please explain: _____

_____

Do you take any supplements or medications? Please list: _____

Do you have any healers, helpers, therapies, or pets? Please list: _____

_____

What role does exercise, sports, and activities play in your life? _____

_____

FOOD INFORMATION

What foods did you eat often as a child?

Breakfast	Lunch	Dinner	Snacks	Liquids

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Female Teen Health History

FOOD INFORMATION (continued)

What is your food like these days?

Breakfast	Lunch	Dinner	Snacks	Liquids

Will family and/or friends be supportive of your desire to make food and/or lifestyle changes? _____

What percentage of your food is home-cooked? _____ Do you enjoy the food? _____

Where do you get the rest from? _____

Do you crave sugar, coffee, cigarettes, or drugs? Please explain? _____

_____

The most important thing I should do to improve my health is: _____

_____

ADDITIONAL INFORMATION

Anything else you would like to share? _____

_____

_____

_____